

# AT Family Therapy, LLC

4380 S. Syracuse St. Suite 460, Denver, CO 80237

303-717-4929 [amy@atfamilytherapy.com](mailto:amy@atfamilytherapy.com) [www.atfamilytherapy.com](http://www.atfamilytherapy.com)

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## **YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE**

### **MEDICAL BILLS**

(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

#### **What is “balance billing” (sometimes called “surprise billing”)?**

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

#### **You are protected from balance billing for:**

##### **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

## **HB19-1174**

### **Out-of-network Health Care Services**

Concerning out-of-network health care services provided to covered persons, and, in connection therewith, making an appropriation.

- Requires health insurance carriers, health care providers, and health care facilities to provide patients covered by health benefit plans with information concerning the provision of services by out-of-network providers and in-network and out-of-network facilities;
- Outlines the disclosure requirements and the claims and payment process for the provision of out-of-network services;
- Requires the commissioner of insurance, the state board of health, and the director of the division of professions and occupations in the department of regulatory agencies to

promulgate rules that specify the requirements for disclosures to consumers, including the timing, the format, and the contents and language in the disclosures;

- Establishes the reimbursement amount for out-of-network providers that provide health care services to covered persons at an in-network facility and for out-of-network providers or facilities that provide emergency services to covered persons; and
- Creates a penalty for failure to comply with the payment requirements for out-of-network health care services.

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### **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

**You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

### **When balance billing isn't allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed, you may contact:**

Colorado Division of Insurance

1560 Broadway, Suite 850

Denver, CO 80202

Phone: 303-894-7499 | Toll free outside the Denver Metro Area: 800-930-3745

Email: [dora\\_insurance@state.co.us](mailto:dora_insurance@state.co.us)

Visit <https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf> for more information about your rights under Federal law.

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